Meningococcal (MCV-4 or MPSV-4)					
Date	MCV4	MPSV	Physician/Clinic	Next	
Given		4		Due	
				Date	
Huma	ın Papil	lloma V	Virus (HPV)		
Dose	Date	Physi	cian/Clinic	Next	
#	Given			Due	
				Date	
1					
2					
3					
Pneur	nococca	al Polys	saccharide (PPV	7-23)	
Dose	Date	Physi	cian/Clinic	Next	
#	Given			Due	
				Date	
1					
2					

Allergies/Vaccine Reactions:

Influenz	a and Ot					
Vaccine	Date	Phy	sician/Clinic		Next	
	Given				Due	
					Date	
TB Skin	Test					
Date	Physician/Clinic Da		Date	Rea	Reaction	
Given	_		Read			
					mm	
					mm	
					mm	

You will need this lifetime immunization record for child care, school, camp, college, the military, travel, employment, or long-term care facilities. Immunizations are also entered into the statewide immunization registry. To request a copy of your immunization record or your child's, call 701.328.3386 or toll-free at 800.472.2180.

Official North Dakota

Lifetime Immunization Record



Name:	
Birth Date:	

Present this record to your doctor or nurse at each visit.

Hepatitis B (Hep B, HBV)						
Dose	Date	Type*	Physician/Clinic	Next		
#	Given			Due		
				Date		
1						
2						
3						
			s, Pertussis (DTaI			
Dose	Date	Type*	Physician/Clinic	Next		
#	Given			Due		
				Date		
1						
2						
3						
4						
5						
Haem	ophilus		zae type B (Hib)			
Dose	Date	Type*	Physician/Clinic	Next		
#	Given			Due		
				Date		
1						
2						
3						
4						
				•		

Dose	Date	Type*	Physician/Clinic	Next
#	Given			Due
				Date
1				
2				
3				
4				
Measl	les, Mu	mps, Ru	ıbella (MMR)	
Dose	Date	Type*	Physician/Clinic	Next
#	Given			Due
				Date
1				
2				
Varic	ella (ch	ickenpo	<u>x)</u>	
Dose	Date	Type*	Physician/Clinic	Next
#	Given		•	Due
				Date
1				
2				

^{*}Use the *Type* column to write the name of the vaccines, including combination vaccines. Record combination vaccines in the section for each individual component.

Pneur	nc	cocca	ıl	Conj	ugate Vaccine (Po	CV-7)
Dose		Date		Гуре*	Physician/Clinic	Next
#	(Given			-	Due
						Date
1						
2						
3						
4						
Rotav	ir	us				
Dose		Date		Гуре*	Physician/Clinic	Next
#	(Given				Due
						Date
1						
2						
3						
Tetanus, Diphtheria, Pertussis Booster						
(Tdap		_				
Date		Type*		Physician/Clinic		Next
Given						Due
						Date